Policy for Adding Health Insurance Coverage to Non-Medicare Health Insurance Plans Offered by the City of Boston

Effective April 9 2013

The intention of this policy is to guide City of Boston Management and members of the Public Employee Committee (PEC) in the process of making changes or additions to health insurance coverage offered to employees and retirees of the City.

1. Federal Health Care Reform

The Patient Protection and Affordable Care Act (PPACA) will require employers to add/change coverage to health plans between the years of 2010 – 2018. These additions or changes in coverage must be implemented but the City may be allowed to decide when to implement the changes; either at the time of release or at the next contract renewal period.

The City of Boston maintained its grandfather status under PPACA through June 30, 2012 and therefore did not implement any changes required under PPACA until July 1, 2012. The City lost its grandfather status due to the implementation of the increases to co-payments and premium contributions effective July 1, 2012.

The following are some examples the City made to its health insurance plans since July 1, 2012:

- Effective July 1, 2012, the City followed the requirement of providing coverage for preventive care services without cost-sharing. This meant that members would pay $0 co-payment for preventive services.

- Effective August 1, 2012, the City followed the requirement of providing coverage for women's preventive services without cost sharing. This meant that women would pay $0 for preventive services. Reform also expanded coverage to include such things as contraceptives and contraceptives counseling.

    - In this case, for its self-insured health plans the City had the option to implement this change on either August 1, 2012 or July 1, 2013 (the next contract renewal period. City Management and PEC Members decided to implement this change effective August 1, 2012 to maintain consistency among all plans. Neighborhood Health Plan, which is fully insured, was going to implement the change effective August 1, 2012.

As this reform continues to roll out, City management and PEC members will work together to make decisions within the guidelines set forth by the Federal government. As these changes come up, items will be put on the next available PEC meeting agenda for discussion. Votes will take place if necessary.

2. State of Massachusetts Mandates

The Governor of the State of Massachusetts will sometimes sign into law mandates for adding services to health insurance plans. Fully insured health plans will always enforce state mandates. In some cases the City will be given the option to implement changes at the time the mandate is established or at the next contract renewal period. Self-insured health plans will allow the City to decide whether or not we want to add the covered services to our health plans.

City Management and PEC Members will work together to decide whether or not to add services to the City's health plans that are state mandates. As we become aware of upcoming state mandates, they will be put on the next available PEC meeting agenda for discussion. Information will be gathered from the health plans to determine the financial impact on claims. Votes will take place if necessary. See the following example:

- A state mandate for covering hearing aids for children and cleft lip/palate surgery for children came out in late January 2013. Neighborhood Health Plan, the City's only fully-insured health plans, gave the City the option of implementing coverage effective January 1, 2013 or July 1, 2013 (the next contract renewal period.)

- At the February 2013 PEC Meeting, City Management and PEC members discussed whether or not to add this coverage to the City's self-insured health plans (BCBS and HPHC.) Information from the health plans showed little impact to claims by adding coverage for these services.

- The parties agreed to implement the coverage effective at the next contract renewal period, July 1, 2013 on all of the City's non-Medicare health plans.

3. Member Appeals Process for Services

Members may files grievances/appeals with their health plan for services that may be denied. These could fall into several categories:

- Continuation of covered services - If a member has reached the limit on a covered service such as physical therapy, they may file an appeal to get an extension of the benefit.

- Services by an out-of-network physician – If a member is enrolled in an HMO and wishes to see an out of network physician, such as a behavioral health specialist, they may file an appeal to see if the health plan will allow them to do so.

- Non-covered services – If a member wishes to receive services that are not covered by the health plans such as experimental cancer treatments, they may file an appeal to see if the health plan will cover services in their particular case.

Members are required to go through the appeals process outlined in their plan handbook. Once a decision has been made, the health plan will notify the member of whether or not the services will be covered.

The health plans for the City of Boston have fiduciary responsibility to make decisions on what services will and will not be covered. In the case of the City's self-insured health plans, City Management and the PEC will not entertain individual requests for coverage which would override decisions made by the health plans.

4. Addition to covered services

If City Management or the PEC would like to make additions or enhancements to the City's health plans which do not fall under Federal Health Care Reform or a State Mandate, one party will need to bring it to the other party to be negotiated.

The City will request information from the health plans to determine the financial impact on claims and premiums.

All changes that are successfully negotiated will be implemented at the time of the next contract renewal period.